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Cultural Resistance to Premarital Health Screening among Prospective Brides and Grooms in Kintamani Bangli, Bali

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Abstract: In 2021, the Indonesian government launched a national stunting strategy outlined in Presidential Regulation No.72. As part of this initiative, a program promoting premarital health screening for prospective brides and grooms was introduced through *ELSIMIL* (*Elektronik Siap Nikah dan Hamil*), Marriage and Pregnancy Readiness App. Despite being linked to marriage registration and targeting all couples, participation remains low in certain regions, such as Kintamani-Bali, due to cultural resistance. This study explores the underlying causes of the phenomenon using qualitative approaches (observation, in-depth interviews, and document analysis) guided by Foucault's power-knowledge theory and Bourdieu's generative structuralism. Findings reveal that cultural resistance stems from the local bridal seclusion "*pingit*" tradition, which prohibits brides from publicly announcing wedding plans, and from beliefs that view illness/health conditions within a couple as a private matter, not a shared social concern. The study highlights the need for culturally sensitive strategies to improve the program's acceptance and effectiveness at the community level.

Keywords: stunting; premarital health screening; *pingit* tradition; cultural resistance, Kintamani Bangli

1. Introduction

Stunting remains a major global public health challenge, affecting approximately 150.2 million children worldwide as of 2024, with the highest prevalence found in South Asia and Africa (WHO/UNICEF/WB, 2025). In Indonesia, the 2024 Nutritional Status Survey (*SSGI*) recorded around

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4.48 million children experiencing stunting, with a prevalence rate of 19.8%. Although this reflects progress from 30.8% in 2018 and 21.5% in 2023, Indonesia still ranks among the countries with the highest stunting rates in the Southeast Asian region (BPS, 2024).

Stunting is defined as poor growth (short stature) in children under five, typically caused by chronic malnutrition and prolonged deficiencies in both the quantity and quality of nutrients (Laili dan Andriani 2019). Important to note that stunting often begins before birth, with preconception health playing a critical role in pregnancy outcomes and early childhood development. Other contributing factors include maternal health, malnutrition during pregnancy, and limited access to quality healthcare. Undiagnosed conditions--such as anaemia, chronic infections, and nutritional deficiencies—can also significantly affect foetal growth and development. Stunting becomes a "vicious circle": a woman who was stunted in childhood is more likely to give birth to a stunted child (Nadhiroh, 2023).

In short, stunting conditions can have long-term consequences on children's physical growth and cognitive development, which will then affect the quality and productivity of the nation's human capital. In response, the Indonesian government has determined that stunting as a national priority issue and launched the National Strategy for the Acceleration of Stunting Reduction outlined in Presidential Regulation No.72/2021. One of its direct implementations is the introduction of ELSIMIL, an electronic registration system for marriage and pregnancy readiness organized by the National Population and Family Planning Board (BKKBN). Targeting all couples and often linked to marriage registration, the ELSIMIL app encourages users to provide detailed information about their marriage plans and complete health assessments at least three months before wedding. The app then generates a certificate confirming their readiness to marry, which is sometimes required for administrative purposes during the marriage registration process. It focuses on preparing prospective brides and grooms for healthy marriages and pregnancies by providing pre-marital and pre-pregnancy health screening and education (Pemerintah Indonesia, 2021).

By identifying and addressing health risks before pregnancy, premarital screening plays a crucial role in ensuring both the physical and mental health of couples. It helps reduce the likelihood of low birth weight, poor foetal nutrition, and early-life health complications—key factors in stunting (Nurfauziyah, 2017). Prospective brides and grooms should have a thorough understanding of reproductive health and proper parenting as part of the family planning

process (Prayogi & Jauhari, 2021). This highlights the urgency of integrating premarital health screening, including counselling, as a new tradition within the customary marriage process, whether practiced in traditional or modern ways.

Despite its importance, premarital health screening in Indonesia faces significant challenges. Many couples, including those in Bali, remain unaware of the program or choose not to participate. In Bali province, where Hinduism is predominant, participation remains low. The 2023 ELSIMIL report recorded only 1,038 individuals out of 2,733 registered prospective brides and grooms (38%) underwent premarital health screening, although this increased to 63.3% in 2024 (1,580 out of 2,493 prospective couples). However, participation varies significantly at the sub-regional levels. Bangli Regency, particularly in the largest district of Kintamani with 48 villages, had the lowest rate. In 2023, only 66 out of 364 registered couples (18%) reported their marriage plans and agreed to premarital health screenings.

Within Kintamani district, half of the villages (24 out of 48) had no couples participate at all, including in the villages of Lembean, Mangguh, Banua, Sekaan, Bayung Gede, Sekardadi, Buahan, Suter, Abang Batudinding, Terunyan, Songan A, Songan B, Batur Selatan, Daup, Belanga, Batukaang, Belantih, Catur, Pursuit, Selulung, Kutuh, Pingan, and Belandingan (ELSIMIL, 2023). In contrast, Serai Village achieved full participation (100%), and Dausa Village followed with 85% (6 out of 7 registered couples). Some other villages such as: Abang Songan Village, Kedisan Village, and Abang Batudinding Village have just begun implementing premarital screening programs that focus on maternal nutrition, reproductive health, and genetic risks.

Such phenomenon raises important questions: what explains the low participation of prospective brides and grooms in premarital health screenings in Kintamani? What form of resistance or indifference are at play? This study focuses on Kintamani District, a mountainous region in Bangli Regency in Bali (see Figure 1), to explore the socio-cultural dynamics behind this phenomenon. The study examines how cultural beliefs, social structures, and discursive practices shape the resistance to the government's discourse on the program. This suggests a contestation between state narratives and local perspectives. This resistance appears to be influenced by cultural factors unique to Kintamani, making it a compelling case for further study. Understanding the reasons behind this reluctance is essential to improving program effectiveness.

Figure 1. Atmosphere of Kintamani Subdistrict (Photo: Dewa Dalem, 2023)

Rather than interpreting low participation as a simple lack of awareness or education, this study views resistance as culturally embedded and politically meaningful. This study applies Foucault's theory of power-knowledge relations and Bourdieu's theory of generative structuralism to explore the underlying dynamics of this resistance. According to Foucault (in Kumbara, 2023a, p. 298), every discourse inevitably produces resistance, struggle, and change, often producing a counter-discourse that challenges dominant narratives. In Kintamani, resistance to premarital health screenings is likely shaped by local knowledge systems and socially constructed or perceived truths that produce distinct power relations. As Foucault argues, truth is not absolute but constructed through discourse (Eriyanto, 2001, p. 66). By applying Foucault and Bourdieu's theories, this research aims to uncover the cultural logics behind resistance and to offer insights for the government strategies that are more culturally aligned with the local traditions and values. Centring the lived experiences of those at the margins of public health policy, the study aims to contribute to broader discussions on cultural diversity, reproductive health governance, and the ethics of intervention.

2. Literature Review

2.1 Premarital Health Screening

Premarital health screening is an essential public health initiative aimed at preventing genetic disorders, infectious diseases, and other conditions that may affect marital and reproductive health (Hanna et al., 2024). Such screenings help detect genetic disorders (e.g., thalassemia, sickle cell anaemia), infectious diseases (e.g., HIV, syphilis, hepatitis B and C), and chronic conditions (e.g., diabetes, hypertension) that could impact a couple's reproductive health (Alswaidi & O'Brien, 2009). Early detection through premarital screening allows for timely medical intervention, informed reproductive choices, and risk reduction strategies, contributing to better health outcomes for couples and their future children (Hanna et al., 2024).

Several countries have institutionalized premarital health screening programs. For example, in Saudi Arabia and several other countries in the Mediterranean and Middle Eastern regions (Gulf Cooperation Council), premarital screening is mandatory for all couples intending to marry, with a focus on genetic and infectious diseases (Saffi & Howard, 2015). In contrast, countries like Indonesia and India encourage screening programs but do not legally require it, leading to varied levels of compliance (Nurmimah, et al, 2022). The success of these programs depends largely on public awareness, supportive government policies, and cultural acceptance.

While widely promoted, premarital health screening programs still have faced resistance in various cultural contexts, particularly in societies where traditional customs strongly influence marital practices. This study examines cultural resistance to health interventions by applying Foucault's power-knowledge framework and Bourdieu's generative structuralism, focusing on habitus and capital to analyse traditional opposition to premarital health screenings.

2.2 Cultural Resistance to Health Interventions

Cultural resistance to health interventions is a well-documented phenomenon, particularly in societies where traditional beliefs and customs play a dominant role in shaping health behaviours. Previous studies have shown that public health policies often encounter opposition when they conflict with long-standing cultural norms (Nugraheni, 2020; Fitriani, 2020). For instance, in Indonesia, resistance to family planning programs has been linked to cultural perceptions that children bring fortune, leading to the rejection of contraceptive methods (Nurmimah, et al., 2022). Similarly, research on maternal and child health programs in rural areas suggests that cultural taboos, economic constraints, and distrust in modern medical practices contribute to non-compliance with government health initiatives (Sukeni, 2010).

In the case of premarital health screenings, studies indicate that opposition often stems from a lack of perceived benefits, financial burdens, and conflicts with traditional marriage customs (Bunu, 2018). While some communities accept health screenings as part of marital preparation, others perceive them as an intrusion into personal or religious practices (Wijaya, 2023). These findings suggest that resistance is not simply due to a lack of awareness but is shaped by historically constructed knowledge systems and embedded social structures, which can be examined through Foucault's and Bourdieu's theoretical frameworks.

Michel Foucault's theory of power-knowledge relations provides a critical lens for understanding cultural resistance to health screenings. Foucault argues that power derives from knowledge and uses it to bring about change and order; it produces and reproduces knowledge in accordance with its own interests (Foucault, 1980). This means that health policies, including premarital screenings, are not merely medical practices but also discursive constructs that compete with existing cultural narratives. According to Foucault, dominant discourses influence societal norms, and resistance emerges when alternative discourses challenge the imposed "truth" (Suyoga, 2022, p. 60).

In Kintamani, the belief in *pingit* myth—a sacred tradition emphasizing the seclusion of brides before marriage—has been internalized as a socially constructed truth that dictates marital customs. This discourse, reinforced by traditional leaders and religious figures, frames premarital health screenings as a disruption rather than a necessity. Since power and knowledge are interdependent (Kumbara, 2023a), the institutionalized knowledge of *pingit* functions as a counter-discourse against government health interventions, leading to cultural resistance.

Previous research applying Foucault's theory in public health contexts has shown that resistance to health programs often stems from deeply entrenched traditional knowledge systems (Haryatmoko, 2016). For instance, studies on vaccine hesitancy highlight how historical distrust in medical institutions and alternative healing traditions shape resistance (Wijaya, 2023). Similarly, the rejection of premarital screenings in Kintamani can be seen as a manifestation of power-knowledge relations, where cultural discourse legitimizes resistance to modern health practices.

Pierre Bourdieu's generative structuralism examines how social structures shape individual agency through the interaction of habitus, field, and capital (Bourdieu, 1990). Bourdieu identifies economic, social, cultural, and symbolic capital as key influences in decision-making. In Kintamani, social capital (family networks and religious authority) and cultural capital (local traditions) might outweigh the perceived benefits of premarital screenings. This aligns with

Fitriani's (2020) findings, which highlight weak policy enforcement as a barrier to program implementation.

2.3 Comparative Insights and Gaps in Existing Research

Previous studies on resistance to premarital health screenings have primarily focused on policy gaps and legal enforcement. Fitriani (2020) argues that the lack of mandatory regulations is the primary reason for low participation in screening programs. However, this study shifts the focus to cultural discourse and social structures, showing that legal enforcement alone is insufficient to address resistance.

Similarly, Nugraheni (2020) examines the impact of premarital counselling on health awareness but does not explore whether couples actively resist screening requirements. This study contributes new insights by demonstrating that cultural resistance is not simply a lack of information, but a structured response shaped by power relations and social norms.

By integrating Foucault's power-knowledge relations with Bourdieu's generative structuralism, this study can assess cultural resistance to premarital health screening through a multidimensional approach (i) discursive struggle of identifying how competing narratives (biomedical vs traditional) shape resistance and (ii) structural influences which examining how social norms, religious values, and kinship systems contribute to rejection

This study builds upon existing research on premarital health screenings, stunting prevention, and resistance to government health policies, offering a new perspective on ideological resistance. Unlike previous studies that focus on the effectiveness of premarital screenings (More, 2021; Nugraheni, 2020) or policy gaps (Fitriani, 2020), this research investigates the hidden cultural mechanisms behind rejection. By applying critical social science methods, this study does not seek to determine whether this resistance is "right or wrong" but rather to uncover the ideological structures at play.

Through Foucault's and Bourdieu's theoretical lenses, this research contributes to a deeper understanding of how power, discourse, and social structures interact in shaping resistance to new health policies. Ultimately, these findings can help policymakers develop more culturally sensitive strategies, ensuring that public health initiatives align with community values and traditions, thereby increasing acceptance and participation.

3. Methods and Theory

3.1 Methods

This qualitative study employed a critical social theory approach within the tradition of cultural studies, which posits that surface-level social

phenomena are embedded with multiple ideologies that operate through social practices (Lubis, 2006). This study was conducted in Kintamani Sub-district, Bangli Regency, Bali, between January and December 2023. Participants were selected purposively. The primary informants consisted of 15 prospective brides and grooms. Supporting informants included seven traditional village heads (*Kepala Desa Adat*), seven community leaders (such as *Kepala Dusun*/*Kepala Banjar*) who typically receive reports when prospective couples plan to marry, 15 field officers from the Family Planning program (*Keluarga Berencana*/*KB*), and five family planning cadres from the Kintamani Sub-district.

Data were collected through observation, in-depth interviews, and document analysis. Observations were conducted from January to June 2023 by participating in community activities, such as wedding ceremonies, the distribution of health screening certificates, and the implementation of premarital health screenings for engaged couples. In-depth interviews, lasting between 30 to 45 minutes, were conducted by using a combination of Indonesian and Balinese languages to ensure effective communication, especially for culturally specific or local Balinese terms. The interviews were guided by a structured protocol. Prior to data collection, informed consent was obtained from all participants, ensuring voluntary participation and clear understanding of the study's objectives, procedures, and potential risks. All interviews were recorded with the participants' consent and subsequently transcribed for analysis.

Data were analysed using a qualitative method with a narrative analysis strategy, as commonly applied in social and humanities research. The aim was to examine sequences of events and allow for diverse interpretations. This study employed both emic and etic analysis techniques. The collected data and information consisting of a combination of raw data from observations, documentation, and interviews (emic) were analysed and interpreted through the researcher's lens (etic) to uncover deeper, and implicit meanings. Data confidentiality was maintained by ensuring anonymity, and all data were only used for study purposes.

3.2 Knowledge-Power Relations Theory

The choice of Foucault's and Bourdieu's theories is justified based on their capacity to explain both the discursive and structural dimensions of resistance to premarital health screenings in Kintamani. Foucault's theory of power-knowledge relations provides a critical framework for understanding how such resistance is constructed and maintained. According to Foucault, "in every discourse, there is knowledge that is considered the truth, used as power through strategies, techniques, tactics, and manoeuvres to discipline bodies, making them obedient and useful to the hidden truth within it" (Wijaya, 2023).

This perspective suggests that what is perceived as "truth" is not fixed but is historically and socially constructed within power structures (Suyoga, 2022, p. 60).

Foucault's notion of the "truth game" further explains how societal truths are continuously shaped by historical and cultural forces rather than being absolute (Suyoga, 2022, p. 60). In this study, resistance to premarital health screenings may not merely reflect individual choice or preference but instead represent a discursive practice deeply embedded in cultural narratives. Myths and customary beliefs surrounding marriage serve as dominant discourses that sustain resistance by positioning health screenings as disruptive to traditional norms. Foucault's argument that "power produces knowledge, and knowledge, in turn, reinforces power" (Kumbara, 2023a, p. 162); Kumbara, 2023b p. 308; Haryatmoko, 2016, p. 17) is evident in how traditional knowledge about marriage is maintained through social practices. By applying this theoretical lens, the study uncovers how discourse legitimizes resistance, and how refusal to undergo premarital health screenings constitutes a manifestation of deeper power relations embedded in local cultural structures.

3.3 Generative Structuralism Theory

Bourdieu's generative structuralism offers a complementary perspective by examining how social structures shape individual and collective resistance to premarital health screenings. According to Bourdieu, social practices arise from the dynamic interaction between habitus (internalized dispositions), capital (resources and assets), and field (social arenas of struggle for power) (Barker, 2005, p. 115).

In this study, habitus refers to the ingrained values and customary practices of the Kintamani community regarding marriage and health. These cultural dispositions influence how individuals perceive premarital health screenings—not as a preventive health measure but as unnecessary interventions that challenge long-standing traditions. Due to the unconscious nature of habitus, resistance to health screenings is often instinctive rather than a product of deliberate choice (Haryatmoko, 2016).

Additionally, capital plays a crucial role in shaping resistance to health screening interventions. Economic capital (financial stability), cultural capital (knowledge, education, traditional customs), social capital (community networks and influence), and symbolic capital (status and recognition) all influence how individuals engage with health policies (Haryatmoko, 2016, p.45). For instance, those with strong cultural and symbolic capital (such as the traditional leaders) may be more inclined to resist screenings, as compliance could be perceived as undermining their authority. On the other hand, individuals with greater

cultural capital (such as in the form of formal education and modern health knowledge) may be more receptive to screenings.

The field, in Bourdieu's framework, represents the space where different social forces compete for legitimacy and control (Harker, et al., 2009, pp. 10-11; Fashri, 2017, p. 106). In Kintamani, premarital health screenings introduce a new form of "truth" that competes with the existing traditional discourse surrounding marriage. The observed resistance reflects a struggle within the field between modern health interventions and entrenched cultural beliefs. This struggle extends beyond mere rejection of medical procedures, but it represents an effort to preserve traditional power structures that govern marriage practices.

3.4 Integrating Foucault and Bourdieu: A Dual Approach to Resistance

By integrating Foucault's theory of power-knowledge relations with Bourdieu's structural analysis, this study offers a comprehensive framework for understanding the persistence of resistance to premarital health screenings. Foucault's perspective helps uncover the discursive mechanisms that shape resistance, showing how traditional myths about marriage construct a "truth" that positions screenings as culturally disruptive. Meanwhile, Bourdieu's concepts of habitus, capital, and field explain how social structures and power dynamics reinforce this resistance through deeply embedded cultural norms and symbolic authority. This analysis helps answer the key research question: "Why do prospective brides and grooms in Kintamani resist premarital health screenings despite being aware of their health benefits?" The findings suggest that such resistance is both discursively constructed (Foucault) and structurally reinforced (Bourdieu), making it a multifaceted phenomenon. Therefore, addressing this issue requires engagement not only with individual attitudes but also with broader cultural and institutional frameworks that sustain resistance.

4. Results and Discussion

The resistance of prospective brides and grooms to premarital health screening in Kintamani represents a cultural practice embedded in everyday life. This resistance is not only a matter of individual preference but also is rooted in ancestral values passed down across generations. It creates a dilemma, whether to preserve longstanding traditions or adopt practices as introduced by the government. In other words, prospective brides and grooms are confronted with a difficult choice, either to embrace new practices and potentially abandon or ignore the old culture, or vice versa to uphold tradition at the expense of state health interventions. More importantly, cultural resistance is not fixed or universal, but it is relational and shaped by context. It is influenced by various

repertoires (which Foucault refers to as "truth games"), whose meanings are specific to a particular time, place, and social relations.

The following section outlines several key reasons why prospective brides and grooms in the Kintamani area reject the practices of premarital health screenings.

4.1 Socio and Cultural Resistance of Prospective Brides and Grooms to the Premarital Health Screening

4.1.1 Sacred Marriage Procession

The government's premarital health screening program is not a mandatory requirement in all wedding ceremonies, particularly within Hindu marriage traditions in Kintamani. This absence of obligation has become a main rationale for many prospective brides and grooms in the region to forgo the practice, including ignoring health-related recommendations from the central government. Additionally, binding regulations—whether in the form of national laws, regional regulations, or customary rules—have not been established, making it more difficult to enforce premarital health screenings before marriage. In contrast, the Muslim community in Indonesia has long adopted the practice of premarital health screening, even before discussions about its widespread implementation emerged. Through the Ministry of Religious Affairs, the Office of Religious Affairs *(KUA)* provides premarital counselling for Muslim couples. One of the key topics covered is reproductive health, which includes the importance of undergoing health screenings before marriage. This demonstrates a more structured and formalized approach to integrate health education into the marriage process.

Marriage in Balinese Hinduism, particularly in the Kintamani region, is regarded as a sacred ritual. It is not only a social contract but also a spiritual obligation, in which the couple is expected to independently fulfil their *dharma* (righteous duty) professionally. Hindu marriage is considered very sacred due to the presence of *Tri Upasaksi* (three types of witnesses in the wedding ceremony). The first is *manusa saksi* or human witnesses including traditional and religious figures; the second is *bhuta saksi* or symbolic witnesses from the unseen or subtle creatures; and the third is *dewa saksi* or divine witnesses including God. This longstanding ritual practice, known in Balinese as *pingit,* has elevated marriage to a deeply sacred tradition. This sacredness is believed to contribute to lower divorce rate, due to the belief in the existence of a sacred bond and responsibility towards the three witnesses. It is further reinforced by the deeply rooted belief in the law of *Karma Phala* (the principle of cause and effect), which shapes the moral and spiritual consciousness of Hindu communities.

In Kintamani, as in other parts of Bali (Figure 2), Hindu wedding ceremonies follow a series of traditional rituals that include: (1) selecting an auspicious day based on the Balinese Hindu calendar, (2) *ngekeb* ceremony (self-control ritual) to prepare the prospective bride and groom, (3) picking up the bride from her residence, (4) *mungkah lawang*, where a messenger from the groom ceremonially comes to knock on the door of the bride's room, (5) *mesegeh Agung*, a welcoming ceremony for the bride, (6) *mabyakala*, a purification ritual for the bride and groom, (7) *mewidhi widana*, a ceremony to inform and honour the ancestors about the new union, (8) *mejauman*, a farewell ritual performed at the bride's residence (Ningsih dan Suwendra, 2020)

Figure 2. Wedding Ceremony IWW and IGR in Abang Songan Village, Kintamani (Photos: Dalem, 2025)

In the traditional Hindu wedding procession in Kintamani, there is no established practice of providing family planning guidance or conducting premarital health screening for prospective brides and grooms. This absence partly explains the resistance toward the newly introduced practice of premarital health screening. From the perspective of religious philosophy, this resistance is understandable, as it is not merely as an individual choice but as a response shaped by deeply rooted traditions, customs, and wedding ceremonies. Communities tend to adhere more strongly to sacred, long-standing traditions than to newly introduced norms or state regulations. It is within the context that the concept of cultural resistance emerges in this study. As expressed by the head of the village.

> *"The absence of official regulations from the government,* Parisada Hindu Dharma, *or the* Majelis Desa Adat *makes it difficult to mandate premarital health screening programs in Kintamani. As a result, the* Bendesa Adat *can only recommend the practice to prospective brides and grooms, rather than enforce it."* (BA1, 51 years old).

This statement highlights how the lack of formal regulations (*awig-awig* in Balinese) issued by *Parisada Hindu Dharma* (Hindu Council) or the *Majelis Agung Desa Adat* (Great Council of Customary Village) to local *Bendesa Adat* (head of customary village) has directly contributed to low levels of acceptance and participation of prospective brides and grooms in adopting the premarital health screening program as part of traditional wedding ceremonies. Without such official guidance, the screening remains a recommended, rather than an institutionalized or component of traditional wedding ceremonies.

4.1.2 Cultural Belief

Individuals, as Foucault argues, are not solely driven by the values and norms they adhere to, but rather by "the discourse developed by people who have the power to speak." (Wijaya, 2023). In Kintamani, as in Bali more broadly, the dominant discourse or known locally as "*Suriyak Siu*" (thousand cheers) reflects a collective prioritization of ancestral traditions. These values are internalized in their conscience and reinforced by elite figures (such as traditional village heads, religious leaders, community leaders). Consequently, adherence to custom is perceived as more legitimate and authoritative than having to follow standard rules from the government.

Related to this, marriage in the view of the Kintamani community is mirroring the meaning of marriage in broader Balinese Hindu society. It is not only a social institution but also a religious obligation (*yadnya* and *dharma*) and one of the four stages of life (*catur grahasta*) that must be passed (Sangging, 2019). One essential purpose of marriage according to the Hindu community's view is to continue the family lineage by bearing good offspring or *suputra* (Adnyani, 2016). Good children are born from a legal marriage characterized by noble character, intelligence, wisdom, and making the family proud. It is even believed that the good children will increase the honour and dignity of both parents (Dian Tri Utami et al., 2023).

Jendra (Widiantari et al., 2019) defines *suputra* as a child who is good both internally and externally. Internally, they are guided by intelligence, ethics, and moral integrity. Externally, they demonstrate good behaviour (*sathya*), moral conduct (*dharma*), compassion (*prema*), peace (*shantih*), non-violence (*ahimsa*), and respect towards God, teachers, leaders, parents, and others. In Hindu teachings, this type of character and behaviour is termed as *Manawa Madhawa* or "human gods," whose behaviour reflects deep reverence for sacred values. It includes the sanctity of marriage (*pinggit*), which has contributed to cultural resistance toward adopting the new practice of premarital health screening before marriage which was promoted by the government.

These beliefs and trust have been deeply rooted and transmitted across generations (*taken for granted*) within the Hindu teachings in Kintamani, evolving into dominant discourses that shape local values, truths, and practices. As a result, introducing new traditions or policies, such as premarital health screening to prevent stunting, faces significant resistance. The government's efforts in Kintamani to mainstream this new practice—especially among adolescents and prospective brides and grooms—clash with long-standing religious and cultural paradigms that are not easily transformed.

4.1.3 Social Stigma

Through deeper engagement with traditional leaders and community figures (the elite group), it becomes evident that the resistance among prospective brides and grooms in Kintamani toward the new tradition of premarital health screening is not primarily rooted in economic or legal issues. This resistance can be better understood through the tendency of human nature, where people are generally willing to invest resources (even financially) if they perceive clear benefits. In fact, many real-life phenomena show that individuals are willing to clash with norms and regulations (even at the risk of conflict) when pursuing something they believe to be important and beneficial. As Foucault's terminology suggests, humans are not driven by norms and rules.

Despite Kintamani's status as a thriving tourist area, where the local government could feasibly provide and offer free premarital health screening, resistance to the practice stems from deep-rooted cultural beliefs. Interviews with several informants (community leaders, traditional leaders, and Family Planning Extension officers) confirm that this resistance to the new tradition of premarital health screening is grounded in the belief system and trust in the myth of *pingit*. This belief system holds that a marriage should not be announced or reported to the public, including to traditional or religious leaders who will later serve as witnesses to the marriage (*human witnesses*). Within this belief system, it is taboo to reveal your wedding plans to the public before the auspicious day (*dewasa ayu*). The people of Kintamani strongly believe that disclosing marriage plans prematurely will have fatal consequences that threaten to annul the marriage. The local culture believes that marriage and pregnancy are something sacred (*pingit*) and it is not good to convey them prematurely. Both the prospective bride and groom as well as their families feel a sense of embarrassment if the wedding plan is revealed in advance. This cultural perspective has been accepted and internalized across generations and taken as unquestioned truth (*taken for granted*).

> *"The reason prospective brides and grooms refuse premarital health screenings is that they feel embarrassed, as it has become a cultural norm in this community to keep marriage plans hidden. Commonly, marriages here are unplanned and happen suddenly"* (Mr. IKM, 47 years old)

Another layer of resistance stems from fear, specifically fear of being diagnosed with certain illness that might make them less ideal for marriage or childbearing. They believe that an unfavourable screening result could jeopardize their wedding plans, especially for the bride. If their poor health condition is discovered early, they fear rejection by the groom or his family.

> *"Prospective brides and grooms rarely or refuse to undergo health screenings because they are reluctant—they do not want to know if they might have an illness. They worry that if they get checked by a doctor or a health centre and discover a disease, it will become a problem. This reluctance makes them avoid the screening process."* (IKT, 49 years old).

Their mindset is that not everyone feels comfortable having their health condition known to the public. This reflects an ideology in which it is preferable to "be sick" (ignore their illness and consider this as a private matter) rather than "accept the role of being sick" (meaning their health condition publicly known, including their future spouse or in-laws), potentially jeopardizing or cancelling the wedding. This aligns with Foucault's concept of episteme—the system of thought that shapes the emergence of knowledge and social truth in a particular era (Parchiano, 2010).

Related to this *episteme* in the Kintamani community, previous research by Made Kerta Adhi (2016) revealed a strong link between poverty and the cultural mindset of the local community. Their study found that persistent poverty in this tourist area is largely driven by cultural values that resist formal government policies. Deeply ingrained cultural values make it difficult for the community to break free from poverty, as seen in behaviours such as begging, laziness, pessimism, lack of motivation, and resignation to fate. Although this current research addresses a different issue, it reveals similar patterns. First, there is a strong internalization of local cultural values among the people of Kintamani. Second, they experience a clash between local traditions and government policies. As a result, prospective brides, and grooms in Kintamani often resist the adoption of new and externally introduced traditions.

Most prospective brides and grooms in Kintamani District are reluctant to report their wedding plans far in advance. In some cases, couples only report their marriage when the bride is already pregnant. This situation indirectly undermines the government's efforts to promote early detection and healthy

pregnancy preparation through premarital health screening. This reluctance is understandable due to concerns about a partner's health condition, particularly infertility. This aligns with Segara & Kuckreja (2024), who state that the primary purpose of marriage in Hinduism is to have offspring. Infertile couples face prolonged social shame, as they are labelled *pan* or *men bekung* (infertile father or mother). As a result, a common saying among young prospective brides and grooms is *"sing beling sing nganten"* (if not pregnant, then no marriage).

> *"The desire of prospective brides and grooms to undergo health check-ups certainly exists. However, nowadays, most couples get married because the bride is already pregnant. If a prospective bride does visit a midwife for a check-up, it is usually because they have purchased a pregnancy test"* (INM, 35 years old, Community figure).

This statement reflects how pregnancy is often prioritized over preparing for a healthy pregnancy. The absence of mandatory policy requiring premarital health screening means this practice is often seen as unimportant. Instead, they place the value of "pregnancy" as highly significant. This means that premarital health screening, as a new tradition among Hindus in Kintamani, is not seen as the only way to improve the quality of life for prospective brides and grooms. As a result, they perceive and internalize it not as a necessity. This perception leads them to disregard the practice and even avoid agents attempting to enforce it.

Ideally, premarital health screening should be conducted three months prior to the wedding, as any detected health issues can be improved within that timeframe. The process begins when the couple reports their wedding plans to local authorities, enabling Family Assistance Team (TPK) cadres to collect data and refer couples for screening and counselling, as shown in Figure 3.

However, despite this well-intentioned process, the practice has not been readily embraced. The cultural perspectives among prospective brides and the broader Kintamani community create a significant barrier to the adoption of a new tradition of premarital health screening in such a short period of time. This mindset, also seen in other areas of Bali, stems from deeply ingrained cultural beliefs, particularly the *pingit* tradition, which views announcing a wedding in advance as taboo and sacred. The *pingit* discourse is part of a broader historical episteme that shapes how knowledge and empowering the community to resist government policies through competing narratives. As reflected in Foucault's view that knowledge and power interact to generate new truths (Wijaya, 2023). In this case, cultural tradition becomes a form of legitimate resistance to externally imposed tradition.

Figure 3. A photo of a prospective bride (in yellow outfit) undergoes a premarital health screening conducted by a healthcare worker (in red outfit), accompanied by a Hindu religious counsellor (wearing a headband) and an officer from the Population and Family Planning Agency (in batik outfit) at the KUA of Kintamani District (Photo source: Dian Rahayu, 2023).

4.1.4 The accumulation of capital

A small number of prospective brides and grooms (*calon pengantin*) in Kintamani believe that the government is not yet ready to implement a premarital health screening program, because it is not supported by adequate funding (particularly the absence of free screening services). This perception aligns with previous research by Fitriani (2020), which found that while the *Premarital Checkup* program has begun to be implemented in Indonesia, its implementation remains suboptimal due to the lack of a clear specific policy regulating health checks for prospective brides and grooms. As a result, most prospective brides and grooms in Kintamani do not undergo health checks before getting married. Similar conditions were observed in this study, as stated by one of the health cadres:

> *"I have communicated and provided education to prospective brides and grooms, as instructed by the government, to encourage them to undergo premarital health screening. However, most of them are reluctant to follow this recommendation because they must cover the cost of the screening themselves. Additionally, they refuse because the screening can only be done at the puskesmas, which is very far from their village. The government should provide health screening facilities at the village level."* (CA1, 41 years old).

Interviews with family support cadres, who are responsible for promoting the premarital health screening program, indicate that economic concerns are one of the key reasons for the rejection of premarital health screenings by prospective brides and grooms in Kintamani. Additionally, the steep and hilly topography of the Kintamani District further discourages couples from traveling from their villages to the district-level *puskesmas* for health screenings. The cadres expressed hope that the Ministry of Health will introduce policies to support the program by providing infrastructure and skilled personnel at the village level. This would allow screenings to be conducted locally in villages, particularly in areas with challenging topography, rather than requiring couples to travel to the district puskesmas.

On the surface, economic barriers (the cost of screening and transportation) and the absence of legally binding regulations requiring premarital health screening contribute to the resistance toward this new tradition. A common discourse among prospective couples and the local community is that *"even without premarital screening, they can still get married."* Many also point to the example of their ancestors, who never underwent such screenings yet still had healthy children. These views highlight the importance of a strong legal and policy framework to support the implementation of the screening program.

Viewed through Bourdieu's theoretical lens, prospective brides and grooms in Kintamani perceive little to no capital gain from undergoing premarital health screenings. This aligns with the fundamental human tendency to be motivated to act when there is capital to be acquired. According to Bourdieu, human behaviour is often driven by pursuit of capital, not only economic (money/financial resources), but also symbolic capital (prestige, recognition) and cultural capital (social status). However, in the case of prospective couples in Kintamani, they are required to spend their own capital—both financially, to pay for the screening, and for transportation costs (fuel) due to the distant location of the puskesmas from their village. Therefore, it is understandable that couples in Kintamani resist this new tradition of premarital health screening, as it does not provide any accumulation of capital for them.

4.2 Discussion

Foucault's theory suggests that within every discourse, there exists knowledge perceived as truth, which functions as a form of power through strategies, techniques, tactics, and manoeuvres to discipline individuals, making them obedient and useful to the "truth" within it (Wijaya, 2023). This implies that discourse is never value-free; to a certain extent it is a historical and social construction that continuously evolves within networks of power (Suyoga, 2022, p. 60).

One such discourse in Kintamani is the belief in the *pingit* (sacred seclusion), a cultural construct that has been internalized as truth and embedded in existing power structures. Among prospective brides and grooms in Kintamani, knowledge of *pingit* has become a form of power that reinforces resistance to the dominant governmental discourse on premarital health screenings. In this context, Foucault's concept of power-knowledge relations helps explain how traditional discourses shape resistance by legitimizing certain beliefs while rejecting others. According to Foucault, "power produces truth, and truth exists within circular relations with the power system that generates knowledge" (Kumbara, 2023a, p. 162; Kumbara, 2023b, p. 308; Haryatmoko, 2016, p. 17). This means that the internalized knowledge of *pingit* among Kintamani's prospective brides and grooms is not merely tradition, but a socially produced truth (*episteme*) that governs their perceptions and actions.

Bourdieu's theory of habitus further explains this resistance as a structured and structuring disposition that influences how individuals act and react in specific situations, often beyond conscious decision-making or adherence to rules (Bourdieu, 2016, p. xvi). In this case, habitus operates as an internalized ideology that drives prospective brides and grooms in Kintamani to reject premarital health screenings. Bourdieu's framework suggests that individuals are more likely to act when they perceive the potential accumulation of capital—whether economic (financial gain), cultural (social status, knowledge), symbolic (prestige, recognition), or social (networks, influence) (Haryatmoko, 2016, p. 45).

However, in the case of Kintamani, premarital health screenings are not perceived to offer any capital accumulation. Instead, they require individuals to expend capital, such as paying for the screening fees or covering transportation costs to distant health facilities. The absence of perceived benefits contributed to cultural resistance, as habitus tends to reinforce action aligned with social or economic benefits. Furthermore, the myth of *pingit* serves as a perception-based justification for rejecting screenings, reinforcing the role of habitus in shaping cultural resistance.

These findings offer a new perspective on resistance to premarital health screenings compared to previous studies. For instance, Fitriani (2020) attributes resistance primarily to the absence of legals or policies mandating for premarital screenings. In contrast, this study argues that resistance is not simply due to policy or legal gaps, but it is deeply ingrained in traditional discourses (particularly *pingit*) that have been socially constructed as knowledge and truth. Similarly, Nugraheni (2020) focuses on the relationship between premarital counselling interventions and prospective couples' knowledge, but it does not explore the existence or causes of resistance. This study goes further by

exploring how cultural norms shape direct opposition to government health policies.

The disciplining of bodies in this study refers not only to individual bodies but also to institutional bodies, including local authorities such as *Bendesa Adat* (customary village heads), *Kepala Dusun* (hamlet heads), and religious leaders. These figures play a vital role in legitimizing and reinforcing knowledge and truth about *pingit*, effectively transforming it into a counter-hegemonic discourse against the government's program on premarital health screenings. This creates a discursive struggle, wherein the traditional discourse of *pingit* competes with the government's modern health discourse, leading to cultural resistance within the Kintamani community.

This contestation between government discourse and the traditional discourse of *pingit* generates a broader social struggle. As a minority discourse, the *pingit* belief is upheld by prospective brides and grooms and the wider community, resisting the dominant governmental narrative on premarital health screenings. Such resistance is not isolated but collectively reinforced through a shared ideological consensus across Kintamani's villages. The widespread transformation of cultural resistance into an established norm is what strengthens opposition to premarital health screenings in the region.

5. Conclusion

This research reveals that resistance to premarital health screenings in Kintamani is not only the result of limited awareness or weak legal enforcement but is deeply rooted in cultural discourse and social structures. Using Foucault's theory of power-knowledge relations and Bourdieu's concepts of habitus and capital, the study demonstrates how traditional beliefs (particularly the practice of *pingit* tradition) shape opposition to government health interventions.

From Foucault's perspective, *pingit* operates as a socially constructed "truth," legitimized by customary and religious authorities. This reinforces the perception that premarital health screenings are unnecessary or even intrusive. Bourdieu's concept of habitus further explains resistance as an instinctive social practice, where the lack of accumulated capital (whether economic, social, or symbolic) discourages compliance with state mandated health programs.

The findings suggest that such resistance is not isolated, but part of a broader contestation between traditional and governmental discourses, where local cultural authority challenges state-imposed health policies. Unlike previous studies that focused on legal gaps, this study highlights the need for a culturally sensitive approach that acknowledges and engages with community norms and socio-economic realities to enhance acceptance of premarital health screenings.

To improve the acceptance of premarital health screening, it is crucial for policymakers to adopt an inclusive and culturally responsive strategy. This includes: (i) decentralizing health services by establishing village-level screening facilities to address logistical and financial barriers; (ii) prioritizing community engagement and cultural mediation by involving local leaders (*Bendesa Adat*, religious figures, and community elders) to promote premarital health screenings as a complementary rather than conflicting practice with tradition; (iii) promoting symbolic incentives by integrating premarital health screenings into traditional wedding ceremonies to allow couples to gain symbolic and social recognition rather than viewing it as a bureaucratic requirement; and (iv) offering subsidized screening programs through government support or partnerships with local organizations that can help alleviate financial constraints and encourage broader participation.

By acknowledging and integrating cultural values into public health strategies, resistance to policy implementation and behavioural change can be mitigated. Health interventions, when aligned with community beliefs and traditions, are more likely to be perceived not as external or foreign impositions, but as meaningful and complementary practices that contribute to both individual and collective well-being.

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